MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR Part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available; we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory:_____California_____
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR, 457.40(b))**

_____
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight **(42 CFR 457.40(c))**:

Name:	Lesley Cummings	Name:	Stan Rosenstein
Position/Title:	Executive Director	Position/Title:	Deputy Director, Medical Care Services
Department:	Managed Risk Medical Insurance Board	Department:	Department of Health Services

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1. The state will use funds provided under Title XXI primarily for (Check appropriate box) (42 CFR 457.70):

1.1.1. ☐ Obtaining coverage that meets the requirements for a separate child health program (Section 2103); OR

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX); OR

1.1.3. ☑ A combination of both of the above.

Introduction

Shortly after enactment of the federal Children's Health Insurance Program, Governor Wilson developed a program for implementing the Initiative in California. He submitted his legislative package to the legislature in August of 1997 and the legislature worked with the Governor to enact the Healthy Families program in the last weeks of the 1997-98 legislative sessions.

With its Healthy Families Program, California seeks to expand access to health care coverage for uninsured children through:

- Creation of a health insurance program for children whose family incomes are above those which provide eligibility for no cost Medi-Cal up through 200% of poverty;
- Changes to the Medi-Cal system which will improve access by simplifying eligibility; and
- Coverage of infants up through the age of two born to mothers enrolled in the Access for Infants and Mothers (AIM) Program whose family income is between 200-300% FPL.

California's program consists of the following pieces of legislation, which are included in the plan as Attachment 2.*

- Chapter 623 (AB 1126 -Villaraigosa) outlines the Healthy Families insurance program which provides affordable private health insurance plans for low-income children either through a health insurance purchasing pool or an insurance purchasing credit. The legislation details program administration, eligibility criteria, monthly premiums, benefits, the program application process, and outreach activities;

*Attachment 1 is a glossary of terms used in the State Plan.

- Chapters 626 and 624 (AB 217 - Figueroa and SB 903 - Lee /Maddy) enact several provisions designed to improve access to Medi-Cal for Medi-Cal eligible children; and
- Chapter 625 (AB 1572 - Villaraigosa/ Gallegos) appropriates start-up funds for the Healthy Families program.

Many children will come to Healthy Families through the Healthy Families "gateway" program, the Child Health and Disability Prevention (CHDP) program. Families of uninsured children receiving health screens from CHDP will complete a pre-enrollment application and be provided with presumptive eligibility for their children for the month of application and the following month. In addition, on the pre-enrollment application, families will be ~~informed about the opportunity for~~ asked if they want to apply for continuing health coverage. Those families ~~wishing to pursue comprehensive~~ that indicate they want to apply for continuing coverage will receive a joint Medi-Cal/Healthy Families mail in application which will need to be completed and returned to the State's Single Point of Enty. ~~be directed either to Medi-Cal or into the insurance program.~~ Presumptive eligibility will continue for those children whose families submit an application for continuing coverage prior to the end of the second month of presumptive eligibility until a final eligibility determination is made by the Medi-Cal or Healthy Families Programs.

In the insurance program, children will receive health coverage like that provided to California's state employees under California's benchmark plan, the California Public Employees Retirement System (CalPERS). They will also receive comprehensive vision and dental coverage patterned after state employee coverage. Children with certain complicated medical conditions will receive treatment of those conditions through California's highly regarded California Children's Services (CCS) program. Similarly, children with serious emotional disturbances will receive treatment of their condition from county mental health departments. This comprehensive child focused benefits package provides children with preventive, full scope, quality health care which will help promote healthier children and, as a result, healthier families for the state of California.

California will seek to ensure that children's health plans become their medical homes by emphasizing preventive services, coordinating with programs that currently serve the uninsured and weaving quality measurement and monitoring into the fabric of the program. California will require specified performance measures in its contracts with plans and will build on these as additional measures are developed.

The Department of Health Services (DHS) will be responsible for implementing the outreach and Medicaid changes proposed in the Title XXI state plan as well as ongoing administration of the CCS and CHDP programs.

The Managed Risk Medical Insurance Board (MRMIB) will be responsible for administering the purchasing pool, the purchasing credit, and the AIM program. MRMIB has a strong commitment to providing affordable quality health care to Californians. MRMIB currently administers three health insurance programs: the Major Risk Medical Insurance Program (MRMIP), a program for medically uninsurable people, the Health Insurance Plan of California (HIPC), a small employer purchasing pool and the Access for Infants and Mothers (AIM) Program, a program for uninsured pregnant women and their newborns. (The state also seeks FFP for infants through age 2, born to mothers enrolled in the AIM program.)

ACCESS FOR INFANTS AND MOTHERS (AIM) PROGRAM

The AIM Program provides comprehensive health benefits for pregnant women and their infants through the age of 2 with household incomes between 200% - 300% FPL. In addition, pregnant women are not eligible for AIM if they are on Medi-Cal or have employer-sponsored coverage (unless the coverage has such high deductibles that MRMIB views the coverage as being tantamount to being uninsured). As approved in California's SPA, FFP is claimed for infants through the age of 1, born to AIM mothers with household incomes between 200% - 250% FPL.

In an effort to streamline public programs, California is in the process of modifying its AIM Program statute to change the eligibility process and benefit service delivery for infants and children up to the age of 2 born to mothers enrolled in AIM. AIM will continue to serve pregnant women with incomes up to 300% FPL. Eligibility, enrollment, plan selection and benefit service delivery through the AIM Program remain the same for the pregnant woman. However, infant's born to mothers enrolled in AIM will be enrolled in the Healthy Families Program from date of birth until age 2. The Healthy Families Program will conduct an annual redetermination prior to the child's first birthday to assure eligibility for the child's second year of coverage, i.e. income equal to or less than 300% FPL.

Providing coverage to infants and children through age 2 born to mothers enrolled in AIM provides a greater selection of health plans, provides access to the CCS provider network for children with an eligible CCS condition, and provides dental and vision coverage. California is in the process of combining the administrative functions of both programs into one administrative vendor. Based on an economy of scale within the Healthy Families Program, pregnant women enrolled in the AIM Program will receive: an increase in the hours of available toll free telephone support; written materials and telephone operators to support more languages; and, most importantly, seamless enrollment for the infants into the Healthy Families Program.

MRMIB has provided to the Administration the necessary modifications to the AIM Program statute and this language is included in the health trailer bill accompanying the Governor's proposed FY 2003-04 Budget. Pending Legislative approval, California submits this SPA to request federal approval for FFP under Title XXI up to 300% FPL for infants, from date of

birth and children through age 2, born to mothers enrolled in the AIM Program and enrolled in the Healthy Families Program.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAMS (C-CHIP)

AB495 (Diaz) (Chapter 648, statutes 2001) authorized the MRMIB to establish a mechanism to permit county agencies, Local Initiatives (LIs), and County Organized Health System (CHOS) to utilize federal Title XXI (S-CHIP) funds not needed by the State for coverage of children or parents in the Healthy Families Program. Funds would be used to expand coverage for uninsured children with income at or below 300 percent FPL and not eligible for no cost Medi-Cal or the Healthy Families Program. California submits this SPA to establish the mechanism for Santa Clara Health Plan, Alameda Alliance Family Care, and San Francisco County Health Plan, all Local Initiatives, and Health Plan of San Mateo, a County Organized Health System for their respective counties. The California Welfare and Institutions Code section 14087 establishes the governing authority for Local Initiatives and County Organized Health Systems.

C-CHIP enrolled children will receive health coverage from the health plan noted above that also serves as the counties' LI or COHS and also a Healthy Families health plan. Health benefits are the same as in the Healthy Families Program, except for the specialized services carved out for CCS. Under the C-CHIP model, children diagnosed with an eligible CCS condition will be referred to the CCS program for a full eligibility determination, including financial eligibility. In the Healthy Families Program, enrolled children with an eligible CCS condition are "deemed" to meet the financial eligibility requirements. In C-CHIP, children that do not meet all the CCS eligibility criteria will have all their medical needs met by the health plan as happens today under the California State Employees coverage that serves as the benchmark coverage for the Healthy Families Program. Children enrolled in the C-CHIP will also receive comprehensive dental and vision coverage patterned after the Healthy Families Program.

C-CHIP will be administered by the LIs and the COHS. Application screening to assure children are not eligible for no cost Medi-Cal or Healthy Families will be done via application assistants who are already trained in Medi-Cal and Healthy Families Program criteria. Enrollment into the LIs and the COSH will occur by the health plan staff. To assure consistency among all the public programs, eligibility criteria are the same as in the Medi-Cal and Healthy Families Programs except that C-CHIP covers income at or below 300 percent FPL.

MRMIB is responsible for review and ongoing monitoring of each of the C-CHIP expansions to assure compliance with federal Title XXI regulations and California's approved state plan.

1.2. ☑ **Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))**

1.3. ☑ **Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)**

1.4. ☑ **Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment (42 CFR 457.65):**

Effective date: July 1, 2003

Implementation date: July 1, 2003

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (42 CFR 457.80(a))

According to the Current Population Survey (CPS) data analyzed by the UCLA Center for Health Policy Research, most California children currently have access to creditable health coverage. According to CPS data for 1995, 7,636,000 children had insurance coverage, with most of those (4.9 million or 53 percent of all children) having coverage through job-based insurance. In 1995, 2,345,000 (25 percent of all children) were served by Medi-Cal, the state's Medicaid program.[1] Another 124,000 children (1 percent) were covered through other public insurance such as Medicare or CHAMPUS, while 291,000 children (3 percent) had access to privately purchased insurance coverage in 1995. However, 1.6 million California children were uninsured, an estimated 17 percent of all California children.

Public Health Care Programs for Children. As was noted above, most California children obtain their coverage through private means. However, a significant number are served through public programs. The public programs under which children may get coverage include the following:

Medi-Cal. California's largest public health insurance program serving children is Medicaid (known in California as Medi-Cal).

- Most children are served under the categorically needy categories (SSI/SSP and AFDC/TANF recipients).

- The Medically Needy program under Title XIX, Section 1902(a)(10)(C) provides benefits to children under age 21 who meet resource requirements and who are determined otherwise eligible.

- The Federal Poverty Level programs under Title XIX, Section 1902(l) provides
benefits to children under age 19 who are determined otherwise eligible. The

1 The California Department of Health Services believes that CPS data significantly underestimate the number of beneficiaries served by Medi-Cal.

FPL programs are as follows:

- For infants up to age one: family income must be at or below 200 percent of FPL, the income (between 185 percent and 200 percent) and the resources of the parents and child are disregarded.

- For children age one and under age six: family income must be at or below 133 percent of FPL.

- For children who have attained the age of six, who were born after September 30, 1983, but who have not attained the age of 19: family income must not exceed 100 percent of FPL.

- State legislation to provide for Medi-Cal coverage under Title XXI of children under 19 and born before September 30, 1983 has just been enacted.

- Presently, resources are counted for children ages 1 to 19 in the FPL program. However, state legislation has just been enacted to disregard the resources of the parents and child in the FPL program which will expand Medi-Cal coverage under Title XXI.

California Health Care for Indigents Program (CHIP). CHIP provides funding to large counties for uncompensated hospital, physician, and other health service costs.

To be eligible for CHIP funds, counties must meet their Maintenance of Effort (MOE), and provide or arrange for follow-up medical treatment for children with health problems and/or medical disorders detected through the CHDP program.

Rural Health Services (RHS). RHS provides funding to small rural counties for uncompensated hospital, physician, and other health services costs.

To be eligible, counties must participate in the County Medical Services Program, meet their Maintenance of Effort (MOE), and provide or arrange for follow-up medical treatment for children with health problems and/or medical disorders detected through the CHDP program.

The program contracts with the State Office of County Health Services for the rural counties' obligation to provide follow-up treatment for the conditions identified in CHDP screens.

Expanded Access to Primary Care (EAPC) Program. EAPC provides financial assistance to primary care clinics serving medically-underserved areas or populations.

EAPC is funded through Proposition 99 tobacco tax monies and serves individuals at or below 200 percent of the poverty level on a sliding scale basis.

Seasonal Agricultural and Migratory Workers Health Program. This program provides financial and technical assistance to primary care clinics serving the needs of seasonal, agricultural, and migratory workers and their families. Individuals pay on a sliding scale.

California Children's Services (CCS). CCS provides funding for medical care for eligible low-income families with children with serious medical problems, such as critical acute illnesses, chronic illnesses, genetic diseases, physical handicaps, major injuries due to violence and accidents, congenital defects, and neonatal and pediatric intensive care unit level conditions. It provides physician, hospital, laboratory, X-ray, rehabilitation services, medications, and medical case management.

To be eligible, individuals must be under twenty-one years of age, have a medical condition covered by CCS, be a resident of the county, have an adjusted gross family income below $40,000 or a projected out-of-pocket medical cost greater than twenty percent of the family income.

Major Risk Medical Insurance Program (MRMIP). MRMIP provides subsidized health coverage to individuals, including children, who are denied coverage by private carriers because of a pre-existing medical condition. People who are eligible for Medicaid or Medicare cannot enroll in this program. Approximately 6% of the program subscribers are children.

Direct health services are frequently provided through community health centers, school based health centers and voluntary practitioner programs.

Access for Infants and Mothers (AIM). The AIM program is a public-private partnership which offers creditable coverage to pregnant women with incomes between 200 percent and 300 percent of FPL and their newborn children through the first two years of life. AIM is administered by MRMIB, which contracts with the private sector to provide subsidized coverage for beneficiaries. To cover the full cost of care, California uses Proposition 99 tobacco tax monies to subsidize subscriber co-payments and contributions, while the subscriber pays two percent of their average annual income. As of September 1997, AIM has provided access to comprehensive health benefits for 28,921 women and 25,735 newborns.

Uninsured Children. The CPS data indicate that the vast majority of uninsured children (1.4 million) live in families with at least one working parent. In fact, 965,000 uninsured children lived in families with at least one parent employed full-time for the entire year. Uninsured rates are highest among children in self-employed

families, but lack of insurance is also prevalent among families in which a parent works for an employer.

There are disparities in California's uninsured children's race and ethnicity as well. CPS data show that 29 percent of Latino children are uninsured, in contrast to 12 percent of Asian American children, 10 percent of non-Latino white children, and 10 percent of African American children. Furthermore, uninsured rates for children vary across geographic regions. CPS data show that 25 percent of children in Los Angeles County and 20 percent of children in Orange County are uninsured. In contrast, an average of 16 percent of children in Central Valley counties, 13 percent in San Diego County, an average of 11 percent in Riverside and San Bernardino counties, and 10 percent in the six county San Francisco Bay Area are uninsured.

CPS data estimates reflect that there are 580,000 uninsured California children whose families have incomes between 100 and 200% FPL and this might qualify as targeted low income children under Title XXI, and thus could potentially be served by the Healthy Families program. Given the sample size drawn for CPS, there are no statistically valid demographic data on this population. A copy of UCLA's analysis of the health status of children between 100 percent and 200 percent of poverty is included as Attachment 3.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: **(Section 2102)(a)(2) (42CFR 457.80(b))**

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

California currently identifies and enrolls uncovered children who are potentially eligible to participate in public programs in several ways:

- DHS administers its Baby-Cal media campaign, which provides extensive outreach to pregnant women about the importance of obtaining prenatal care, and informs them that, if they have modest incomes, state programs are available to help them. With its annual $6 million budget, Baby-Cal uses a media campaign, operates a toll-free line which, among other things, refers callers to Medi-Cal or the AIM program (as applicable), and conducts outreach through a network of roughly 350 community based organizations (CBOs).

- ~~Child Health and Disability Prevention (CHDP),~~ California Children's Services (CCS), and Women, Infant and Children (WIC) providers

identify children who may be potentially eligible for Medi-Cal and refer the family to the appropriate office to apply. State statute requires CCS applicants to fill out a Medi-Cal application.

- Child Health and Disability Prevention (CHDP) providers identify children who are uninsured and may be eligible for no cost Medi-Cal or the Healthy Families Program, grant presumptive eligibility in one of the two programs, and encourage families to apply for continuing coverage for Medi-Cal and Healthy Families.

- To facilitate the application process, Medi-Cal outstations eligibility workers in locations which serve large numbers of potentially eligible children, such as disproportionate share hospitals, prenatal clinics and federally qualified health centers.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

The Baby-Cal campaign described in Section 2.2.1. targets pregnant women who may be eligible for participation in the AIM program. AIM also works with three community-based outreach contractors in various regions of the state to distribute informational materials via mail and at public events. AIM's contractors conduct other innovative activities such as educating insurance agents about the program, conducting a telemarketing campaign, and producing public service announcements. AIM also conducts outreach through the use of an application assistance fee paid to individuals and entities that assist families in filling out the AIM application.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. ***(Previously 4.4.5.)*** **(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))**

The Healthy Families program consists of four components: expansions of coverage under Medi-Cal (as described in Section 2.1); establishment of a purchasing pool for children with family incomes up to 200% FPL (who are ineligible for no-cost Medi-Cal); an aggressive outreach and education campaign to make the public familiar with the availability of health coverage for the uninsured; and provision of coverage under the AIM program for infants and children through age 2, born to mothers enrolled in the AIM Program with family incomes between 200 -300% FPL. This section

concentrates on the insurance program and AIM as Medi-Cal's administration is in accordance with California's Title XIX plan.

Insurance Program

The insurance program will serve children whose family income falls below 200 percent FPL but who are not eligible for no-cost Medi-Cal. The program has been designed to have a smooth interface with Medi-Cal and includes a number of provisions to ensure that the insurance program enrolls only targeted low-income children.

Coordination with Medi-Cal:

- Under Title XXI, California will expand Medi-Cal eligibility to implement a resource disregard for children whose countable family income is at or below the appropriate FPL in the Medi-Cal program. Thus, eligibility for both programs will depend only on a family's income. Eligibility workers, CHDP providers, and other organizations assisting families will be able to use an income chart to refer children to the appropriate program.
- Healthy Families will compare its participant list against Medi-Cal's enrollment files to ensure that children do not already have creditable coverage through Medi-Cal.
- To provide families moving from Medi-Cal to Healthy Families with time to enroll in Healthy Families, the Department of Health Services will implement one month of **"**continued eligibility" for Medi-Cal covered children whose family income is at or below the appropriate FPL who lose eligibility for no cost Medi-Cal due to increased family income or increased age of a child.

Coordination with employer-sponsored coverage. The insurance program has been designed to ensure coordination with existing private coverage to reach only targeted low income children:

- The program has a coverage "firewall" -- a prohibition against covering children who have had employer sponsored coverage within 3 months prior to applying for the Program. MRMIB is authorized to increase the length of the period to 6 months if it finds it is covering substantial numbers of children who were previously covered under employer-sponsored plans.
- The program's enabling statute prohibits insurance agents and insurers from referring dependents to the program where dependents are already covered through employer sponsored coverage.
- The program's enabling statute makes it an unfair labor practice for an employer to refer employees to the program for dependent coverage where the

employer provides for such coverage or for an employer to change coverage or change the employee share of cost for coverage to get employees to enroll in the Program.

Outreach. A central component to the design of Healthy Families is an extensive outreach campaign. The outreach for the new Healthy Families program is designed to be performed by CHDP providers, community-based organizations, county health agencies, and other entities that are geared to assist targeted low-income families in obtaining needed health and related services. CHDP providers will provide early medical screenings and immunizations (following Early Periodic, Screening, Diagnostic, and Treatment (EPSDT) guidelines), grant presumptive eligibility for uninsured children under 200% of poverty in the Healthy Families and Medi-Cal programs, and encourage families to apply for continuing coverage ~~and will perform a critical eligibility screening and referral function~~ for both Healthy Families and Medi-Cal. Healthy Families outreach will be coordinated with efforts to inform families about the enhancements to children's Medi-Cal coverage that accompany the implementation of the new Healthy Families program. As with the AIM program, entities that are likely to have contact with large numbers of children in the target population, such as school districts and day care centers, and individuals such as insurance agents will be paid a fee for assisting families in filling out the Healthy Families application. The outreach campaign is further outlined in Section 5 of this plan.

Integration of traditional and safety net providers. Counties as well as clinics and certain providers are primary sources of care for Medi-Cal beneficiaries and the uninsured, including children.

Given the critical safety net role these systems play in serving targeted children, the state will facilitate their participation in the purchasing pool. The following features are intended to assist with this process:

- MRMIB will encourage managed care plans to subcontract with safety net providers and require them to report annually on the number of subscribers selecting these providers.
- MRMIB will allow the health plan that has the highest percentage of traditional and safety net providers in its provider network to charge a discounted premium.
- County managed care systems (county organized health systems) are allowed to participate in the pool and given two years to obtain a commercial health plan license.
- MRMIB will give priority in contracting to plans with significant numbers of providers who serve uninsured children.

In summary, the Managed Risk Medical Insurance Board (MRMIB) and the Department of Health Services (DHS) have established a variety of mechanisms by which to coordinate in the administration, monitoring, and evaluation of the programs described in the plan. The mechanisms include:

- Both DHS and MRMIB report to the Secretary of the Health & Welfare Agency who can ensure that both agencies are operating under consistent policies and procedures;
- Kim Belshé, the Director of DHS, is a MRMIB Board Member. Thus, every issue before the Board is one which Ms. Belshé can comment on to other Board Members and vote on. Furthermore, the Health and Welfare Agency sits on MRMIB as a ex-officio member;
- DHS and MRMIB have created a Healthy Families Core Workgroup consisting of DHS' and MRMIB's senior management. The workgroup meets every other week to ensure coordination of the program. During these meetings, workgroup members provide status reports on the various projects being implemented and discuss implementation issues. This workgroup will continue to meet on a routine basis even after the Healthy Families program has opened;
- DHS staff has provided input to MRMIB staff on every version of the MRMIB Healthy Families regulations, as well as on the model contracts, negotiations and provided input to DHS staff on the application form common to both Healthy Families and Medi-Cal (Medicaid) for children, the outreach contract, and the outreach and media approach. MRMIB has also consulted with DHS staff on a range of issues such as Medi-Cal quality standards, Medi-Cal threshold language requirements, and the definition of traditional and safety net providers;
- DHS has created a new high-level management position (Associate Director) to facilitate coordination of the program within and between agencies. DHS has filled this position with an individual who served as Deputy Director of MRMIB from 1991-1996; and
- DHS staff attends MRMIB's public meetings, including board meetings, and meetings with potential vendors to explain the model contracts.

COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM (C-CHIP)

The county insurance program, similar to the Healthy Families Program, serves uninsured children whose family income do not exceed 300 percent FPL and who are not eligible for no cost Medi-Cal or the Healthy Families Program and who are otherwise eligible for S-CHIP funding. C-CHIP is a county based program only available in counties that have local funds allocated for its implementation. Eligibility

and enrollment in these programs are operated by the local county government, LIs or COHSs.

Coordination with Medi-Cal and the Healthy Families Program. Since the C-CHIP projects are sponsored and funded from local funds, there are built in financial incentives to local counties to assure coordination with Medi-Cal and the Healthy Families Programs. More children can be covered at the county level using local dollars if they are not financially sponsoring children who could otherwise be covered by state and federal dollars.

- C-CHIP will use the same income standards and deductions as the Medi-Cal and Healthy Families Programs to assure consistency among the programs.
- C-CHIP will use a resource disregard when determining eligibility, again to assure consistency with the Medi-Cal and Healthy Families Programs.
- At the time of initial application, a Medi-Cal and Healthy Families screening will occur. Applications with children screened to Medi-Cal or Healthy Families will be submitted to the State's single point of entry for processing. Most counties have indicated that they will use Health-e-App, the state's internet based electronic application that provides a Medi-Cal and Healthy Families eligibility screening as the mechanism by which to assure children are not enrolled in C-CHIP in error.
- As with the initial eligibility determination, annual reviews will occur to assure continued eligibility for C-CHIP, including the Medi-Cal and Healthy Families screening.
- The State will also modify its annual review process to include forwarding applications to counties known to have a C-CHIP when a child is determined to have income above Healthy Families guidelines.

AIM

The authorizing statute for the AIM program includes the same prohibitions as mentioned above regarding insurance agent referral and unfair labor practices. It also will not provide coverage to a woman on Medi-Cal or who has employer-sponsored coverage (unless the coverage has such high deductibles that MRMIB views the coverage as being tantamount to being uninsured.)

California has historically served mothers and infants through its AIM program even if they have high deductible insurance coverage ($500 or more), because at the income of AIM mothers (200-300 percent FPL), out of pocket expenditures are so unaffordable that most mothers will be unable to use the insurance.

In an effort to improve coordination and simplification in public programs, MRMIB is

in the process of modifying its AIM Program statue to provide health delivery to infants and children through the age of two, born to mothers enrolled in AIM, to be enrolled in the Healthy Families Program. While enrolled in the Healthy Families Program, these children will also undergo an annual redetermination prior to their first birthday to assure that the household income remains at or below 300% FPL. Prior to the child's second birthday, the Healthy Families Program shall again conduct an annual redetermintion to assess whether the child's household income is at or below 250% FPL, and therefore can remain in the Healthy Families Program. The benefits of this change includes: greater health plan choice; access to the CCS provider network for children with a CCS eligible condition; and the simplification process of being reassessed as Healthy Families eligible based on a streamlined annual redetermination process compared to completing a complete application, if the family is aware that the program exists. Therefore, after these changes are implemented, the AIM Program will continue to exist as a pregnancy only program. Thus, MRMIB will bill for children under age two whose family income is between 200 percent and 300 percent of FPL and who are uninsured.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.**

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42CFR 457.490(a))

Overview of the Comprehensive Healthy Families Delivery System

California's approach is to serve targeted low income children through an integrated system of care. The central component of this system is a new program to provide creditable health insurance coverage through managed care, a program which will be administered by MRMIB. MRMIB will provide managed care to targeted low-income children between ages 1 and 19, and children under age 1 with incomes between 200 and 250 percent FPL through a health insurance purchasing pool. Through the purchasing pool the state will deliver a comprehensive range of health services to targeted low income children. The state will use the power of pooled purchasing not only to obtain affordable coverage for uninsured children but also to demand high quality services for children.

Many children will come to Healthy Families through a "gateway" program, the CHDP program. CHDP offers preventive health services to children under 200 percent of poverty. ~~When~~ Prior to ~~children receive~~ receiving services from a CHDP provider, ~~they will either be referred to~~ families of uninsured children will complete a pre-enrollment application and be provided with presumptive eligibility for their children for the month of application and the following month. In addition, on the pre-enrollment application, families will be asked if they want to apply for continuing coverage through Medi-Cal or Healthy Families. Those families interested in continuing coverage, will receive a joint Medi-Cal/Healthy Families mail in application which will need to be completed and returned to the State's Single Point of Entry. Presumptive eligibility will continue for those children whose families submit an application for continuing coverage prior to the end of the second month of presumptive eligibility until a final eligibility determination is made by the Medi-Cal or ~~to the~~ Healthy Families insurance program. Should follow up treatment be required for a condition identified in the CHDP screen, Medi-Cal or the Healthy Families insurance program (depending on which program the child qualifies for) will cover the cost of care provided to children ~~for 90 days prior to enrollment~~ during the period of presumptive eligibility. Low income children who are ineligible for Medi-Cal or the insurance program will be referred to counties for treatment.

To meet the special needs of children, the Healthy Families program will also ensure the provision of necessary specialized services beyond those offered through the comprehensive insurance package in a coordinated manner. The CCS program and county mental health departments will address the significant needs of the minority of children whose needs may not be fully met under an insurance benefit package. The CCS program will provide case management and treatment for chronic, serious, and complex physically handicapping conditions, while county mental health departments will provide appropriate services to meet the needs of seriously emotionally disturbed children. Both programs will reimburse providers for these specialized services. Children receiving such services will continue to have their primary health needs served through the insurance program. Allowing those specialized services to be provided as a complement to, but outside of, the managed care setting is consistent with recent actions in the Federal budget reconciliation act which prohibit mandatory enrollment of children with special medical needs in managed care.

To promote a smooth interface between Healthy Families and Medi-Cal, Medi-Cal will be enhanced through a resource disregard for children in the federal poverty level program, accelerated coverage for all children under 100 percent of the federal poverty level, and an additional one month of continued eligibility to allow children whose families become ineligible for Medi-Cal time to become enrolled in the insurance program. In addition to program integration, these features will promote greater coverage of children who are already eligible for, though not enrolled in, Medi-Cal. Under this Medicaid expansion, children without health insurance will receive their coverage under Title XXI funding. Children with health insurance will receive their coverage under Title XIX funding with the applicant's other health coverage requirements being applied.

Targeted low income children under age 2 whose mothers are enrolled in AIM and whose families have incomes between 200- 300% of federal poverty level will be served through the Healthy Families Program. The Healthy Families Program will redetermine eligibility prior to the child's first birthday. Prior to the child's second birthday, the Healthy Families Program will redetermine eligibility for the S-CHIP Healthy Families Program.

The authorizing statute for Healthy Families also requires the state to assess the need for specialized services in two additional areas: rural health and substance abuse.

Rural health. The Department of Health Services (DHS) is authorized to operate up to five pilot programs in rural areas should the coverage provided through the insurance programs be insufficient in particular rural areas or for particular populations, such as migrant workers or American Indians. DHS will be meeting with stakeholders in rural areas as well as holding a public hearing in the fall of 1997 to begin to assess these

issues. A final determination will be made in early 1998, after MRMIB has finished negotiations with plans for the purchasing pool and, thus, are aware of the extent of the coverage in rural areas. Should DHS, relying on the advice of the Rural Health Policy Council and the County Medical Services Program Board in evaluating the need for supplemental services, determine that supplemental services are needed, California will submit an amendment to this plan.

Substance abuse. The authorizing statute directs MRMIB, in consultation with the Department of Alcohol and Drug Programs, to assess the feasibility of providing supplementary services for substance abusers. The core benefit package includes those services made available to state employees, but some have argued that additional services are necessary for the target population. MRMIB will report to the legislature on the need for additional services by April 15, 1998. The state will submit an amendment to this plan if it wishes to expand substance abuse services.

Healthy Families Purchasing Pool

Delivery System. For the majority of eligible families, MRMIB will offer access to health plans through a subsidized consumer choice purchasing system. The pool will be built around the concepts used successfully by organized purchasers such as the California Public Employees Retirement System (CalPERS) and HIPC -- price competition among managed care health plans, family choice of plans, performance based contracts with plans, and reliance on existing private sector delivery systems. In the purchasing pool, many of the same health plans and networks available in the employer market will be available to beneficiaries, providing broad access to health care providers. Most of the plans participating will be health maintenance organizations (HMOs), but it is possible that one or more preferred provider organizations (PPOs) will also participate. PPO's participate in several of MRMIB's programs and are a particularly effective means of providing coverage in areas with little or no penetration by HMO's.

Plan Contracting. MRMIB is authorized to contract with licensed health plans and health insurers as well as Local Initiatives approved by the Department of Health Services to provide service to Medi-Cal beneficiaries, County Organized Health Systems (COHS), and federal Health Insuring Organization demonstration projects such as Santa Barbara's COHS. Participating plans will be under the regulatory authority of California's Department of Insurance or Department of Corporations, and subscribers will be able to take any benefit grievances to those regulators. Eligibility grievances are appeal able to MRMIB. COHS are presently overseen by the Department of Health Services, but will be required to obtain Knox-Keene licensure within two years to participate in Healthy Families.

To assure that health care providers currently serving low income families are given

the opportunity to participate in the program:

- MRMIB will encourage private managed care plans to subcontract with safety net providers and require them to report annually on the number of subscribers selecting these providers.
- MRMIB will allow the health plan in each county that has the highest percentage of traditional and safety net providers in its provider network to charge a discounted premium.
- County managed care systems (county organized health systems and Local Initiatives) are allowed to participate in the pool and, in the case of COHS's, given two years to obtain licensure as private health plans.
- MRMIB will give priority in contracting to plans with significant numbers of providers who serve uninsured children.

Plan Contracting Process. The process that MRMIB will use to contract with health plans will be the process it uses to contract with health plans under its three existing programs. MRMIB will first adopt (emergency) regulations detailing the eligibility, benefits and appeals process for the program. It will then issue model contracts, one for the administrative function, and one each for health, dental, and vision plans, which specify MRMIB's contracting requirements. The model contracts issued by MRMIB serve as the basis of negotiations with all vendors. These contracts will contain numerous requirements, ranging from quality standards, participation of safety net providers, communication standards, grievance procedures, and manner of payment. Many of the provisions will be aimed at developing a medical home for children. These provisions include:

- Performance standards regarding provision of health promotion service, such as immunizations;
- Requirements that families receive ID cards, evidence of coverage documents, and physician and hospital directories on the effective date of coverage;
- Requirement to report on grievances; and
- Requirements to publish materials in specified languages.

MRMIB traditionally contracts with health plans for two years. It continually refines and improves the requirements of the contract prior to each new contracting period. It will be able to incorporate in subsequent contracts the indicators of a high quality medical home once such measures have been developed.

Both the regulations and the model contracts will be adopted in public session by MRMIB after the public has had the opportunity to testify on them. Once the model contracts are adopted, MRMIB staff will meet with any and all potential contractors. Those interested in participating will be required to submit signed contracts, together

with their price for services, at a certain time. MRMIB staff will review contracts for compliance with requirements and MRMIB will select contractors offering the state the best value. MRMIB can select as few or as many health, dental, and vision plans as it deems appropriate and is not constrained to select the lowest bidder(s).

MRMIB has a reputation for expeditious implementation of the programs it administers. Each of the three existing MRMIB programs opened for enrollment within nine months of enactment of authorizing legislation. Mindful of the urgent needs of California's uninsured children, MRMIB has adopted a similarly aggressive schedule for enrollment to the pool.

Administration. The purchasing pool and purchasing credit components of the program will be privately administered under the oversight of MRMIB. A mail-in application process will be used, and eligibility determination will be completed within an estimated ten days. The application (intended to be as similar as possible to a planned redesigned Medi-Cal application for children) will be designed to verify the income eligibility of families and to screen them for access to employer sponsored coverage as well as coverage under no cost Medi-Cal. As is done in the AIM program, income eligibility will be verified using copies of last year's federal income tax forms or current year wage stubs. A random sample of applications will be audited using the Income Eligibility Verification System (IEVS) on an on-going basis to ensure the fiscal integrity of the program.

The administrative contractor will be responsible for eligibility determination, premium collection, transmission of enrollment information to health plans, and printing and mailing of application materials.

In addition, an application assistance payment will be made to entities able to refer large numbers of children to the program. The types of entities anticipated to be authorized by MRMIB for receipt of the fee include state maternal and child health contractors, school districts, parent-teacher associations, Healthy Start sites, county health departments, county welfare offices, licensed day care operators, and insurance agents or brokers. A flat fee of $50 will be paid to the referring entity for every family that is determined to be eligible for and enrolled in the program.

Quality Oversight. Consistent with its administration of its three existing programs, the MRMIB will look to the state regulatory entities to assure the basic quality of health plans with regard to financial stability, adequacy of network, and appropriateness of medical policy. In addition, to ensure that a health plan becomes a child's medical home, the best practices available for quality improvement and monitoring will be adopted. Such performance standards could include assuring the accessibility of services (such as wait time for appointments) and the delivery of preventive treatments (such as improvements in the percentage of children that are

fully immunized by age two).

Coordination with Other Programs. MRMIB will encourage all plans to develop protocols to screen and refer children needing services beyond the scope of the program's benefit package to public programs providing such services and to coordinate care between the plan and the public programs. This could include the regional centers for the developmentally disabled, county substance abuse programs and local education agencies.

MRMIB will also be coordinating eligibility with the state Medi-Cal program by referring children who appear to be eligible for Medi-Cal to the county for follow-up. MRMIB and Medi-Cal are also assessing the feasibility of using the same application form for both programs so that applications could simply be mailed for processing.

The application assistance fee, which MRMIB will pay for referrals of eligible children, is another feature which will facilitate coordination with public and private entities. MRMIB will specify those agencies and persons in regulation after public hearing, but anticipates authorizing a wide range of entities including insurance agents, PTA's and county maternal and child health contractors.

Outreach Efforts. A statewide outreach effort will be launched to inform parents about the child health services offered through programs such as Healthy Families and Medi-Cal. The outreach program will use mass media, toll free phone lines, community based organizations, and coordination with other state and local programs to deliver messages that are culturally and linguistically appropriate. (See Section 5 for a more detailed description of the outreach activities.)

Child Health and Disability Prevention Program

To maximize access, continuity of care, and ease of administration, the existing CHDP program which provides preventive health screening examinations for children with family incomes of less than 200 percent of the federal poverty level will be integrated into the design of the Healthy Families program. CHDP is a logical point of entry for the target population to be served for many reasons:

- Targeted low income children eligible under Title XXI currently access preventive health services offered through CHDP;
- CHDP providers are likely to be the providers in the child health insurance plans and serve as the "medical home" for children enrolled in plans; and
- Integrating CHDP as a component of Healthy Families provides the new program with acceptability and credibility for providers and families.

To assure that uninsured children in the target population are enrolled in comprehensive health, dental and vision services, California will provide presumptive eligibility in the Medi-Cal and Healthy Families Program on site at the CHDP provider offices. The Medi-Cal Program has already submitted a state plan amendment to CMS that expands the entities qualified to determine presumptive eligibility for children under age 19 to include CHDP providers. This state plan was approved by CMS on May 7, 2003 and was implemented in the Medi-Cal Program July 1, 2003. Presumptive eligibility coverage will begin on the month of the pre-enrollment application. Once presumptive eligibility has been established for either Medi-Cal or the Healthy Families program, children will receive services through the Medi-Cal fee-for-service delivery system for both Medi-Cal and Healthy Families. This state plan amendment requests approval for Title XXI funding for those Healthy Families benefits used by children screened Healthy Families eligible based on the information provided on the pre-enrollment application. As of April 1, 2003, the Healthy Families Program no longer pays for services related to health, dental or vision care needs identified prior to Healthy Families enrollment, also referred to as the "90 day retroactive eligibility". ~~move smoothly into enrollment in either the Healthy Families or Medi-Cal programs, California will adopt a form of limited retroactive eligibility. Once enrolled in one of the programs, a child will be provided 90 day retroactive eligibility to the date of the screening visit for payment for services related to health, dental or vision care needs identified at the initial visit. The cost of these services will be reimbursed on a fee for service basis (at Medi-Cal rates) during the period from application to enrollment and will be paid by Medi-Cal for children enrolled in Medi-Cal and by MRMIB for children enrolled in the insurance program.~~

A streamlined system ~~will be~~ has been developed in which uninsured children seeking services with a CHDP provider will be provided presumptive eligibility. Families will receive a Medi-Cal Benefits Identification Card (BIC) for each child granted presumptive eligibility. On the pre-enrollment application, families will indicate whether they want to apply for continuing coverage. Those families that do not indicate an interest to apply for continuing coverage will be provided coverage under presumptive eligibility beginning the month of the pre-enrollment application and ending the following month. Families that indicate they do want to apply for continuing coverage will be sent a joint Healthy Families/Medi-Cal mail in application to complete and return to the State's Single Point of Entry (SPE). For coverage to continue, the State's SPE must receive the joint application before the end of the second month of presumptive eligibility. Continuing coverage will remain in effect until a final eligibility determination is made by either the Healthy Families or Medi-Cal program. Children eligible for the Healthy Families program will be enrolled in a Healthy Families contracted health plan as selected by the family. ~~will provide for identification of eligibility for Healthy Families or Medi-Cal at the time of a health screening so that providers have a mechanism for delivering care and receiving payment. The services available during this period of retroactive eligibility will be~~

~~specified in regulation.~~ Appropriate referral will also be made to the CCS program if the problem identified through the screening examination appears to be a CCS eligible condition. To ensure continuity of care whenever possible, referrals for treatment services will be made to providers in the Healthy Families insurance plan which the family has chosen. During the period between application and enrollment, the county CHDP program can assist with identification of providers, scheduling appointments for identified health care needs, coordination of services, and completion of the application form.

Specialized Services

Mental Health. A basic benefit package of mental health services will be provided by the health care plans. This basic package for mental health treatment includes 20 outpatient visits, and 30 inpatient mental health days per year. While it is anticipated that the great majority of the mental health needs of children will be met under the insurance benefit package, it is recognized that some seriously emotionally disturbed children will require more specialized mental health services. Consistent with the treatment of similarly situated privately insured populations, these children are eligible for specialized mental health services through the county mental health system of care. Children with serious emotional disturbances (estimated at between 3-5% of the general population) will be referred by the health care plan to the county mental health program for treatments, pursuant to a Memorandum of Understanding (MOU) between the two organizations for any needed additional mental health services.[2] The required MOU will formalize this important arrangement. (The description of services available is in Attachment 6.) The county mental health program will coordinate the delivery of mental health and other health services with the health care plan for those children who meet the criteria of serious emotional disturbance.

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2 *Definition of Serious Emotional Disturbance from Welfare and Institutions Code:* "For the purposes of this part, 'seriously emotionally disturbed children or adolescents' means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of he Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of he following criteria:

(A) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of he following occur:
  (I) The child is at risk of removal from home or has already been removed from the home.
  (II) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

(C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code." [For the purposes of the Child Health Initiative, the age range will be expanded to age 19 years].

County mental health programs will provide mental health treatment services directly or through contracts with private organizations and individual providers. The requirements for provider selection and quality improvement for these mental health services will be consistent with those used for the Medi-Cal program for a similar population.

California Children's Services Program. Integrating the CCS program into Healthy Families is a logical way to ensure that uninsured low income children with serious health conditions will continue to have access to a program highly respected by the medical community because of its focus on high quality care. Children with chronic, serious, and complex physically handicapping conditions are best served by systems and programs which have been organized specifically to serve them. It is important that care not be disrupted and that continuity and quality of services be maintained. With these goals in mind, plans will be required to refer CCS-eligible children to the CCS program for the treatment of CCS-eligible conditions.

CCS, the Title V designated program for children with special health care needs, provides medical case management and payment for health care services for those children with eligible medical conditions who live in families with annual incomes below $40,000. Coverage is, and will be, limited to coverage of the specific condition. The program establishes standards for approval of inpatient hospital facilities and pediatric specialty and subspecialty providers delivering care to eligible children. The program also has an extensive system of special care centers located at tertiary medical centers at which multi-specialty, multidisciplinary teams deliver coordinated inpatient and outpatient care to children with chronic medical conditions. The centers include cardiac, chronic pulmonary disease, hematology and oncology, myelomeningocele, hemophisia, sickle cell, renal, infectious disease/immunology, hearing and speech, metabolic disorders, inherited neurologic disease, limb defect, gastroenterology, craniofacial anomalies and endocrinology. The program also approves neonatal intensive care, pediatric intensive care, and pediatric rehabilitation units.

CCS program staff determines the appropriate source of health care for eligible children, assist families in accessing care, and identify other needs of the child and family that could impact the care of the eligible condition.

The services to treat the CCS eligible medical condition of a child enrolled in Healthy Families will not be the responsibility of the contracting health plan in which the child is enrolled. The CCS program will continue to authorize the medically necessary services to treat the condition using the program's regulations, policies, procedures and guidelines in determining the appropriateness of providers, and the necessity for services. CCS will expand the systems of communication that have been instituted to work with Medi-Cal managed care plans that have CCS services "carved out" from

their capitation rate. Local CCS programs carefully coordinate the authorization and delivery of specialty and subspecialty services with the primary care provider to which the child is assigned.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM

Delivery System. Service delivery in the C-CHIP will be provided by the counties' LI or COHS. These health plans are health maintenance organizations and also contract with MRMIB to participate in the Healthy Families Program. Having these same plans available is an asset to families in that they may assume continuity of care should they go from enrollment in the C-CHIP to Healthy Families and visa versa.

Administration. The C-CHIP will be administered by the county LI or COHS. The LI or COHS will be directly responsible for final C-CHIP eligibility determinations, enrollment in the LI or COHS, distribution of written materials including correspondence, billing statements, Evidence of Coverage booklet, and premium collection, etc. MRMIB will oversee program activities to assure compliance with federal Title XXI regulations. MRMIB has reviewed the following materials to provide this assurance:

- The C-CHIP application, to assure that all necessary data is collected.
- Policies and procedures for determining eligibility (including citizenship/immigration status) and enrollment, documentation requirements, appeals processes, and enrollee protections such as continued enrollment during an appeal.
- All C-CHIP template correspondence to be used in communicating with the applicants.

Medi-Cal

As part of the Healthy Families program, the state enacted a number of changes to Medi-Cal designed to ease the entry of Medi-Cal eligible children into the Medi-Cal system and establish a more consistent eligibility standard for children. Specifically the state enacted legislation to:

- Disregard resources of the parent and child, for children between ages 1-19 in the Federal Poverty Programs, thereby expanding coverage under Title XXI for children whose families meet Medi-Cal's income standards but who have not met its resource standards;
- Provide one month of continuous eligibility to be used by families who no longer qualify for no share of cost Medi-Cal to transition to Healthy Families private insurance;
- Require development of a simplified Medi-Cal form which can be mailed in;

and

- Make eligible for Medi-Cal at 100% or less of FPL, children under age 19 who were born before September 30, 1983 (children age 14-19). This means that children aged 6-19 will be eligible at 100% or less of FPL.

Funding for children who meet the criteria above who are uninsured will be funded by Title XXI while funding for children with private coverage will be by Title XIX.

The delivery system for targeted low income children served by Medi-Cal will be consistent with the existing Title XIX state plan. The appropriate Title XIX state plan amendments are included with this proposal. See Attachment 4.

AIM

The AIM program provides creditable coverage to pregnant women with incomes between 200 percent and 300 percent of FPL and their newborn children through the first two years of life. AIM is administered by MRMIB, which contracts with the private sector to provide subsidized coverage for beneficiaries. Because Medi-Cal currently serves infants under 1 year of age through 200 percent of FPL, infants through age 1 up to 250 percent of poverty served by AIM fall within the income range of targeted low income children. Consistent with the C-CHIP projects, the same income disregards will be applied to children born to mothers enrolled in AIM through age 2. AIM's delivery system and contracting standards are virtually identical to that of Healthy Families' purchasing pool described above. Nine health care service plans participate in AIM, which offers statewide coverage, and the vast majority of all beneficiaries are offered a choice of two plans in each region (three in Los Angeles County).

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. **(Section 2102)(a)(4) (42CFR 457.490(b))**

Health Insurance Programs

MRMIB will contract with managed care plans which will receive a specified amount per enrollee per month.

Virtually all of the plans will be regulated by California's Department of Corporations (DOC) under a body of law - the Knox-Keene Act - established specifically for

managed care plans.[3] The Knox-Keene Act prescribes rules for the organization of health maintenance organizations and other managed care entities. It specifies plan standards, marketing rules, and consumer disclosure requirements. It also establishes fiscal solvency requirements and quality assurance standards. Specific Knox-Keene requirements include:

- *Medical decision making*. The Knox-Keene Act requires medical services to be sufficiently separate from administrative and fiscal management so that medical decisions are not unduly influenced by fiscal concerns. DOC conducts an onsite medical survey at least every three years. Plans have physician medical directors responsible for medical decision making and directing quality assurance programs.

- *Basic health care services*. Knox-Keene plans must provide the following basic services: physician services, inpatient and outpatient services, diagnostic and therapeutic lab and radiologic services, home health care, preventive health care, and emergency health care, including ambulance and out-of-area coverage. In addition, there are a number of statutory mandates to provide or offer specific benefits.

- *Accessibility of services*. DOC must review and approve provider networks and contracts. Primary care services must be within 30 minutes or 15 miles of the enrollees' residence or workplace. Regulations require at least one primary care provider (FTE) for every 2,000 enrollees as guideline. DOC may require more providers depending on the area, population density, and other factors. Different requirements may apply in rural or medically underserved areas. DOC assures reasonable access to ancillary services and tertiary care.

- *Quality assurance*. Plans must have quality assurance programs to review quality of care, which includes as one component a utilization review system. Regulations require a program directed by health providers to review the quality of care being provided, and to identify, evaluate and remedy problems related to access, continuity and quality of care, utilization and monitoring of plan providers.

- *Financial viability*. Plans must file quarterly and annual financial statements and other financial reports. Plans must meet "tangible net equity" requirements and a financial and administrative audit is conducted at least every three years to monitor plan financial viability.

3 Plans regulated by the Department of Insurance are also eligible to participate in the health insurance program as are county organized health systems which are overseen by the Department of Health Services under rules set forth in the Title XIX plan.

- *Consumer protection*. Plans must maintain internal grievance procedures for plan enrollees and appeals may be made to DOC if grievances are not resolved to the enrollees' satisfaction. DOC reviews and approves plan contracts, disclosure forms, marketing materials and advertising to be sure that consumers receive fair and accurate information.

In addition to the Knox-Keene statutory and regulatory requirements for all health plans, MRMIB has developed a number of features for its programs to assure that enrollees are receiving needed health care. A number of these are discussed in Section 7. However, two features associated with the purchasing pool should be pointed out here:

- *Purchasing Pool Structure*. MRMIB will use a purchasing pool structure under which families can choose from among a number of health plans available in their area. Once a year, the program will have an open enrollment period in which families can change health plans for any reason, if they so choose.

  This "vote with your feet" feature means that enrollees dissatisfied with their health plan can easily change to another -- and likely will even be able to switch to one that also includes their own provider. Thus, health plans must work to satisfy their enrollees if they hope to attract and keep large numbers of enrollees.

- *Risk Assessment/Risk Adjustment*. MRMIB is one of the country's leaders in developing and operating a risk assessment/risk adjustment (RARA) mechanism. One of the purposes of RARA is to provide fiscal relief to plans that have attracted a disproportionate share of higher risk enrollees. This mitigates the incentives that a health plan may have to avoid (or provide inadequate treatment to) a higher risk person or population because they will be high cost. Stated alternatively, it seeks to assure that plans with a higher than average risk mix of enrollees have the resources needed to serve their population. MRMIB has successfully operated a RARA mechanism in the HIPC since 1995 and intends to implement such a mechanism in the Healthy Families pool.

Child Health and Disability Prevention Program

The CHDP program, an entity that provides for presumptive eligibility in the Healthy Families and Medi-Cal programs, ~~which~~ will serve as an initial screening and treatment entity ~~as well as a referral source~~ for Healthy Families and Medi-Cal eligible children, and will develop~~s~~ and distribute~~s~~ medical guidelines for health assessments

which CHDP providers use as guidance for the CHDP examinations. Duplicate copies of the health assessment reports are submitted by the providers to the appropriate county CHDP program. The program uses the copies to assist with referrals as needed to assure treatment was provided and to assess the quality of the exams done by individual providers. The state CHDP program analyzes statewide data on the health assessments to determine if children are receiving appropriate preventive health services. ~~Treatment services will be limited to services for which a need was identified in the health assessment. CHDP will develop prior authorization procedures for high cost services. CHDP will respond to requests for prior authorization within 72 hours so that treatment is not delayed.~~

Specialized Services

California Children's Services Program. CCS is a medical case management program. Program staff determine the appropriate source of health care for eligible children, assist families in accessing care and identify other needs of the child and family that could impact the care of the eligible condition. The program prior authorizes payment of funds for medically necessary services to treat the child's eligible condition and for hospitalized children, does concurrent reviews. This authorization is based on the program's regulations, policies, procedures and guidelines. The program also approves pediatric intensive care units and refers only to specialists meeting standards established by the program.

Mental Health. The county mental health program has responsibility for case coordination and authorization of services to treat serious emotional disturbances. Utilization management requirements for this program will be consistent with those used for the Medicaid program for a similar population and described in the Title XIX plan.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM

Health Plan Regulatory Oversight. These plans are regulated by the Department of Managed Health Care, previously the Department of Corporations, under the Knox-Keene Act. The Knox-Keene Act, as previously stated, prescribes rules for the organization of health maintenance organizations and other managed care entities. It specifies plan standards, marketing rules, and consumer disclosure requirements. It also establishes fiscal solvency requirements and quality assurance standards.

Specialized Services.

California Children's Services Program. Children who are enrolled in the C-CHIP and diagnosed with an eligible CCS condition will be referred to the CCS Program for an eligibility determination based on CCS eligibility criteria: CCS eligible condition,

residence within the county, and income within CCS financial guidelines. Children not eligible for CCS services shall receive their medically necessary services via the health plan delivery system like the California State Employees system that serves as the benchmark. C-CHIP eligible children do not have deemed financial eligibility for CCS services; AB495 requires that expansion services be provided without state expense.

Medi-Cal

The expanded Medi-Cal services provided under Title XXI will be provided in accordance with the routine utilization review procedure used in the Medi-Cal program consistent with the Title XIX state plan. The amendments to the Title XIX state plan that allow for these services can be found in Attachment 4.

Access for Infants and Mothers (AIM)

AIM, like the Healthy Families purchasing pool, operates in a managed care environment. The utilization controls used in the program are like those discussed in the above section on the purchasing pool.

Section 4. Eligibility Standards and Methodology. **(Section 2102(b))**

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.**

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))**

4.1.1. ☑ **Geographic area served by the Plan:** The S-CHIP plan is available statewide. The C-CHIP is available in Santa Clara, Alameda, San Francisco and San Mateo counties.

4.1.2. ☑ **Age:** Children from ages 0 to 19 will be served within the insurance program. Children ages 14-19 with family incomes 85% to 100% FPL will be eligible for Medi-Cal through a Title XXI expansion.

4.1.3. ☑ **Income:** Presumptive eligibility will be granted to eligible uninsured children in families with household income between 100-200% FPL that receive a health screen or immunizations by a CHDP provider. Income levels for continuous enrollment in the Healthy Families Program is between ~~Between~~ 100-200% FPL for the insurance program and 200-300% for infants and children through age 2, born to mothers enrolled in AIM. Medi-Cal uses specific exemptions from income, as is detailed in California's Title XIX State plan. In determining eligibility for Healthy Families, Medi-Cal income exemptions will be applied and all income over 200% FPL but less than or equal to 250% FPL will be disregarded in calculating household income. If the income exemptions and income disregard reduce income to 200% or less FPL, the child will meet the Healthy Families Program income criteria. In determining eligibility for C-CHIP, Medi-Cal income exemptions will be applied and all income over 200% FPL but less than or equal to 300% FPL will be disregarded in calculating household income. If the income exemptions and income disregard reduce income to eligibility to 200% FPL or less and the child is not eligible for the Healthy Families Program, the child will meet the C-CHIP income criteria.

4.1.4. ☐ **Resources (including any standards relating to spend downs and disposition of resources):** The insurance program has no resource requirements. Consistent with this approach, California will waive the resource Medicaid requirements for all children in the Federal Poverty

Level program under Medi-Cal. The C-CHIP will also waive resource requirements consistent with other public programs.

4.1.5. ☑ **Residency (so long as residency requirement is not based on length of time in state):** Children must be residents of California. They must also meet the citizenship and immigration status requirements applicable to Title XXI. Eligibility for C-CHIP will require residency within the county that sponsors an expansion program and meet the citizenship and immigration status requirements applicable to Title XXI.

4.1.6. ☐ **Disability Status (so long as any standard relating to disability status does not restrict eligibility):**

4.1.7. ☑ **Access to or coverage under other health coverage:** Children are ineligible for the insurance program if they have been covered under employer sponsored coverage within the prior 3 months (with certain exceptions described in Section 4.4.4) or if they are eligible for (no cost) Medi-Cal or Medicare coverage. To participate in AIM, pregnant women must not have employer sponsored coverage or no cost Medi-Cal at the time of application.

4.1.8. ☑ **Duration of eligibility:** Presumptive eligibility begins on the first of the month in which a CHDP pre-enrollment application is completed, and continues for the following month. In addition, on going presumptive eligibility will continue for those children whose families submit a Healthy Families/Medi-Cal application to the State's Single Point of Entry prior to the end of the second month of presumptive eligibility. For those families that submit the joint application prior to the end of the second month of presumptive eligibility, their children will continue to be presumptively eligible until a final eligibility determination is made. Annual eligibility determination for Healthy Families. Medi-Cal will establish one month bridging eligibility for children whose family income increases beyond Medi-Cal's eligibility threshold for no-cost Medi-Cal coverage, but does not exceed Healthy Families limits. Infants aged 0-1 in the AIM Program are determined eligible at the time their pregnant mother enrolls and will be redetermined prior to the child's first birthday for continued eligibility. C-CHIP eligibility is for twelve months, at which time an annual eligibility determination will occur.

4.1.9. ☑ **Other standards (identify and describe):**

- Enrollment in the insurance program and AIM will be limited to the number of children that can be served within appropriated funds.

- To be eligible for the insurance program, families must enroll all of their children, pay the first month's family contribution, and (if selecting coverage through the purchasing pool) agree to remain in the pool for at least six months, unless other coverage is obtained and demonstrated. To remain enrolled in the insurance program, families must make their premium payments. Those who fail to do so will be disenrolled and not allowed to apply again for six months. However, state law stipulates that MRMIB may waive the six month exclusionary period of disenrollment for good cause.

- Children are ineligible for the insurance program if they are eligible for any California Public Employees' Retirement System Health Benefits Program(s), if they are an inmate in a public correctional institution or if they are a patient in an institution for mental illness.

- At the time of application, children enrolled in C-CHIP cannot be eligible for no cost Medi-Cal or the Healthy Families Program.

- To be eligible for AIM, families must agree to pay 1.5% of the family's gross income. The child's mother must have lived in California for at least six months prior to applying for coverage under the program.

- Infants and children in families with household income at or below 300% FPL, born to mothers enrolled in AIM will be enrolled in the Healthy Families Program from the time of birth. As such, all cost sharing requirements in the Healthy Families Program shall apply.

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B)) (42CFR 457.320(b))

4.2.1. ☑ These standards do not discriminate on the basis of diagnosis.

4.2.2. ☑ **Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.**

4.2.3. ☑ **These standards do not deny eligibility based on a child having a pre-existing medical condition.**

4.3. Describe the methods of establishing eligibility and continuing enrollment.
(Section 2102)(b)(2)) (42CFR 457.350)

Presumptive Eligibility

Effective July 1, 2003, families of uninsured children seen during a CHDP health screening visit will complete a pre-enrollment application. Eligible children will be granted presumptive eligibility and will receive a Medi-Cal Benefits Identification Card (BIC) to access services in the Medi-Cal fee-for-service delivery system. Presumptive eligibility will be granted beginning the first of the month in which the pre-enrollment application was completed, and continue through the following month. In the pre-enrollment application, families will also be asked if they want to apply for continuing coverage in the Healthy Families or Medi-Cal programs. Families that indicate yes will be sent a joint Healthy Families/Medi-Cal mail in application. For presumptive eligibility to continue, the State's Single Point of Entry must receive the joint Healthy Families/Medi-Cal application prior to the end of the second month of presumptive eligibility. For those joint Healthy Families/Medi-Cal applications received prior to the end of the second month of presumptive eligibility, presumptive eligibility will continue until a final eligibility determination is made. All services provided under presumptive eligibility will be in the Medi-Cal fee-for-service delivery system but paid for by Title XIX or Title XXI as appropriate. California will only claim Title XXI funding for Healthy Families benefits already approved in California's state plan.

Prior to granting presumptive eligibility, California will screen applications against the Medi-Cal Eligibility Database System (MEDS) to assure that ineligible children are not granted presumptive eligibility. Children ineligible for presumptive eligibility are those already enrolled in Medi-Cal and Healthy Families, and children known to MEDS to have a confirmed ineligible immigration status.

Insurance Program

MRMIB will contract with a private company to conduct eligibility determinations, premium collection, payment of the application assistance fee and other enrollment functions. This is the same process that it uses for MRMIB's three existing programs.

The State has researched federal law to determine if a proposed administrative vendor who is also a health care plan would violate any federal provisions applicable to title XXI of the Social Security Act. The State has determined that only one federal law, 42 USC 1396a (4)(C), as amended by the Balanced Budget Act of 1997, applies to the Healthy Families Program pursuant to Section 2107(e) of Title XXI. Section 1396a (4)(C) requires that certain officers, employees, and independent contractors be prohibited from engaging in any activity prohibited under Section 207 and 208 of Title 18 of the United States Code. The State intends to comply with these sections and does not think that having a health care plan act as the administrative vendor would violate 42 USC 1396a (4)(C).

Although Title XXI is subject to 42 USC 1320a-7b(b), the State has determined that the section does not apply to the Healthy Families Program because the duties of the administrative vendor would not be activities covered under the section. The vendor will not arrange for health care services or auto assign applicants to any given plan. The applicant makes the choice of health plans and the vendor is prohibited from recommending or steering an applicant to any plan.

In addition, 42 USC 1396v, as amended by the Balanced Budget Act of 1997, which prohibits a health plan from being an enrollment broker for a Medicaid managed care organization, is not applicable to Title XXI.

The firewall requirements established for the administrative vendor (found on pgs. 14, 15, 24, and 25 of the Administrative Model Contract) include:

- Conducting administrative functions of the program in a separate physical area from other business activities;
- Creating an administratively separate organizational structure for staff responsible for the program;
- Blocking access to program databases and files by other parts of the Contractor's organization unless expressly authorized by the State;
- Not using prospecting lists or any other information obtained for the program for use in the Contractor's other business activities;
- Maintaining an open door policy with participating plans, allowing those participating plans to observe its administrative processes, and granting those plans the ability to influence how they are represented by the program's representatives;
- Establishing and maintaining stringent security measures on all hardware, software and program files to ensure the confidentiality and integrity of applicant and subscriber files, and to restrict access to confidential materials;
- Requiring the vendor to develop a process to assure that participating plans' concerns regarding eligibility and enrollment issues are resolved in a timely

manner;

- Requiring the administrative vendor to develop and implement a process whereby benefit or participating plan customer service related concerns are traced and transmitted to the appropriate plan for resolution. A summary of these data must be provided monthly to the State;
- Not allowing the administrative vendor selected (health plan or not) to use its company name on program materials. Rather, all materials will refer to the Healthy Families Program;
- Requiring state approval of all published materials, including materials which describe health plans in the application brochure;
- Using scripts prepared by each plan to answer phone inquires about coverage provided by the plan; and
- Requiring any health, dental or vision plan seeking to become the administrative vendor to include in their proposal a statement of how it will assure the separation of plan operations from administrative vendor operations.

Additionally, health plans seeking to become the administrative vendor have suggested additional firewalls in their proposals. MRMIB intends to incorporate these additional firewalls in their contract with the administrative vendor, if it selects a health plan. These include:

- Involving MRMIB in the development of performance based incentive programs for the managerial staff to ensure that the incentives are disassociated from any potential conflicts of interest;
- Providing on-site work space for a MRMIB employee located within the physical unit where HFP administrative activities will take place. The employee will have unrestricted access to HFP administrative facilities and operations, be invited to all internal meetings regarding HFP administration, be able to monitor telephone calls between administrative staff and applicants, and be able to monitor all data systems functions;
- Recording all telephone calls. Tapes of the telephone calls will be made available to MRMIB, health plans, and external auditors, as required;
- Creating links to participating plan websites on the HFP website; and
- Conducting regularly scheduled meetings with participating plans to discuss issues regarding the administrative function. Participating plans will help create the agenda for these meetings. MRMIB will approve any actions proposed at the meetings.

If MRMIB selects a health plan as its administrative vendor, it will use the following strategies to monitor for violations of conflict of interest, in addition to the strategies noted above:

- MRMIB staff periodically will make calls to the vendor posing as potential applicants to see if vendor personnel make any effort to induce them to choose their company's health plan;
- MRMIB will investigate any complaints by competing health plans or applicants regarding steerage of applicants to one plan over another; and
- MRMIB will track enrollments by health plan and conduct eligibility audits on a periodic basis.

The Healthy Families' administrative vendor will not have the ability to or the responsibility for determining Medicaid eligibility. Medi-Cal application processing and determination will be made by the county welfare office. The application contained in the joint application package contains a worksheet designed to assist families who appear to be eligible for Medi-Cal in mailing their application directly to the county welfare offices. Families who appear to be Healthy Families eligible will mail their applications to the MRMIB administrative vendor who will determine Healthy Families eligibility or ineligibility. If the vendor determines that the child meets Medi-Cal eligibility criteria, the vendor will deny the Healthy Families application, notify the family, return the premiums to the family and, with the family's consent, forward the application to the county welfare office for processing.

Alternatively, in the event that the family incorrectly applies to Medi-Cal, the county welfare offices will, with the family's consent, mail their application to the MRMIB administrative vendor. Once a family has mailed in an application, the "system" will take on the responsibility to see that the application is processed by the appropriate program, but neither will make the other's determination of eligibility.

Families will fill out a simple application and mail it with accompanying supporting documents to MRMIB's enroller. The application/enrollment brochure will be published in English, Spanish, and any other languages designated by the Department of Health Services as a "threshold" language for the Medi-Cal program. Families with questions about the form will be able to call the administrative vendor through a toll free number. Families will be able to speak to the administrative vendor's staff in English or Spanish, and may communicate via other languages through a telephone translation service. MRMIB is authorized to pay certain agencies and individuals such as insurance agents and parent-teacher organizations an application assistance fee for assisting a family with a successful application. The supporting documents that families send to the enroller will include documentation of income eligibility which the administrative vendor will verify using copies of the past year's federal income tax forms, or current year wage stubs. The administrative vendor will audit a random sample of applications on an ongoing basis using the IEVS system to confirm income information. The Systematic Alien Verification System (SAVE) or an appropriate alternative will be used to verify immigration status.

The administrative vendor will review the application within a 10 day time frame and either return it to the applicant for additional information, enroll the child(ren) in a purchasing pool health plan or enroll the child(ren) in coverage available through the employer. Coverage under the purchasing pool plan will begin 10 days after the application has been determined complete.

On behalf of a child not yet born, families may apply for Healthy Families Program coverage up to three months prior to the expected date of delivery. The infant's 12-month period of eligibility will begin within 13 days after MRMIB receives a notice of the birth. Families that apply for coverage of an infant up to three months prior to birth and experience a change in income prior or after the infant's birth may apply for no-cost Medi-Cal. California will not begin covering children under age 1 in Healthy Families until October 1, 1999, or 90 days after the enactment of the 1999-2000 state budget.

Eligibility will be continuous for 12 months and reestablished annually, unless a child is otherwise made ineligible.

Enrollment in a Health Plan. Families will select their children's health plans when applying for the program. When families are seeking coverage through the purchasing pool, they will choose from among the plans participating in their geographic area. The number of plans from which families can choose will vary depending on the geographic area, as there are fewer managed care plans available in rural areas. In the state's population centers, MRMIB expects families to be able to choose from between 10-15 health plans, dropping down to one or two plans in the most rural parts of the state.

Descriptions of each health plan will be included in the program's application brochure. In the description each plan will list its toll free numbers and describe how families can get copies of its provider directories and evidence of coverage documents. The application and enrollment materials will be available in English, Spanish, and any other threshold language designated by the Department of Health Services.

MRMIB will provide participating families with an annual open enrollment period during which time they may choose to switch plans.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM

Health plans (the counties' LI or COHS) will administer the local insurance expansion programs. Since the LI or COHS health plan is the only health plan available in each C-CHIP project, there are no issues related to steerage. The LI and COHS staff will

be responsible for eligibility determinations even though state trained application assistants will be used to identify eligible children, assist in completing applications and screening children for the appropriate program: no cost Medi-Cal, Healthy Families or the C-CHIP. The LI and COHS will also be responsible for premium collection, program enrollment and distribution of health plan materials.

Applications received by C-CHIP that include children potentially eligible for no cost Medi-Cal or the Healthy Families Programs will be forwarded to California's Single Point of Entry for processing. Because of obvious incentives, we believe a quality screening will occur since the Medi-Cal and Healthy Families Programs are state and federally funded while the C-CHIP is county and federally funded. Counties will want to stretch local dollars and still meet objective of reducing the number of uninsured children within the county.

In establishing local expansion programs, the C-CHIPs have adopted most of the Healthy Families rules, including eligibility, documentation, and benefits. The C-CHIPs have established their own applications, although most resemble the one used by the Healthy Families Program.

Medi-Cal

Eligibility will be established and enrollment continued in a manner that is consistent with the state's Title XIX plan.

AIM

MRMIB presently contracts with a private company, Care 1st, which serves as the administrative vendor for the program. Effective January 1, 2004, MRMIB will have a new administrative vendor contract to handle daily operations of both the Healthy Families and AIM Programs.

Families fill out a four-page application and mail it, with accompanying supporting documents, to MRMIB's administrative vendor. Applications are available in English and Spanish. Certain agencies (such as county health departments or maternal and child health contractors) and providers (such as physicians and registered nurses) specified by MRMIB can obtain a $50 application assistance fee for assisting a family with their (successful) application. The supporting documents families send include documentation of income eligibility which the administrative vendor verifies using copies of the past year's federal income tax forms, or current year wage stubs.

Care 1st reviews the application within a 10 day time frame and either requests additional information from the applicant or enrolls the pregnant woman in the purchasing pool health plan selected by the woman. Coverage under the purchasing

pool plan begins 10 days after the application has been determined complete.

Eligibility is determined once -- at time of application to the program-- and continues for 60 days post partum, for the mother and up to the child's first birthday. Upon notification of birth, the infant will be enrolled in the Healthy Families Program. Prior to the child's first birthday, the Healthy Families Program will conduct an annual redetermination for the child's second year of coverage. Prior to the child's second birthday, the Healthy Families Program will redetermine eligibility for the S-CHIP Healthy Families Program. The state seeks FFP for the health care costs of the child up to age two for children with family incomes between 200% and 300% of poverty.)

In California's state plan submission, we indicated that MRMIB would be using an application assistance fee of $50 which would be available to certain groups specified in MRMIB's regulations. These included child care centers, Parent-Teacher Associations (PTA's), and insurance agents and brokers, among others. The amount of $50 was obtained from the payment which MRMIB made for application assistance in two of its other programs (MRMIP – the high risk pool – and AIM). Originally, the fee had been set to reflect the cost for an agent or broker's assistance for application assistance and health plan selection. The fee assumed an agent/broker cost of approximately six percent of premiums, an amount which represented the low end of the agent reimbursement spectrum in the commercial market.

Since submission of the plan, MRMIB and DHS have concluded that it would be inconsistent with federal requirements to allow any of the application assistance fee-eligible entities to assist with health plan selection. As a sizeable portion of the $50 fee had included reimbursement for working with the applicant on health plan selection, DHS and MRMIB decided to reduce the fee.

Staff then assessed the cost of providing application assistance by a community-based organization (CBO). Assuming that the assistance would be provided by a paraprofessional staff person for 300 days per year, and would include four client interviews a day/site, an hour of travel, and two and a half hours/day for phone calls, administrative work, and technical assistance to other applicants, the cost/call would be $25.13. These costs are based on actual costs for the WIC program and do not include any time spent on assisting with health plan selection.

Thus, adjusting the application assistance fee to reflect the fact that assisters will not help applicants with health plan selection, MRMIB and DHS have set the fee to $25.

4.3.1. Describe the state's policies governing enrollment caps and waiting lists (if any). (Section 2106(b)(7)) (42CFR 457.305(b))

☐ **Check here if this section does not apply to your state.**

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. **(Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3))**

In the Medi-Cal program, California will implement a resource disregard for children in the Federal Poverty Level program. In the insurance programs, MRMIB will use income disregards similar to Medi-Cal's to ascertain whether a child should be a Medi-Cal or Healthy Families enrollee. Once it is clear that a child is not Medi-Cal eligible, his or her gross family income, will be reviewed to determine whether the child is Healthy Families eligible. Thus, the new insurance program and Medi-Cal will be substantially similar in terms of eligibility determination criteria.

DHS and MRMIB are developing a joint application for children's Medi-Cal and Healthy Families, and will add two questions on resources to the Medi-Cal only form of the joint application to assess whether children are eligible for the program because the State no longer performs an asset test. These questions do not provide sufficient information for identifying those children. We would suggest establishing a threshold amount above the Title XIX income eligibility, in which families within the threshold amount would then be asked qualifying questions beyond the two that were proposed, so as to further detail their resources. We believe this approach would provide you with the necessary information to properly account for the newly eligible children.

First, it is important to acknowledge that HCFA and California agree on the policy change that California has enunciated in the state plan -- implementing the resource disregard. The conversations we have had with HCFA have not been on whether to do it but how to document the amount for which California can claim enhanced FFP. In our view, this "how" question is an administrative issue which we can work out over time, and is not a policy issue which requires resolution before HCFA can approve our plan.

HCFA's request that California add additional resource questions to the Medi-Cal mail-in application form appears to be contradictory to HCFA's prior direction on this issue and to be at odds with our mutual goal of providing Medicaid coverage to children who meet eligibility criteria but who are not

enrolled. Further, we are concerned that there is some confusion on how our questions will work as they relate to eligibility for Medi-Cal.

With the resource disregard, a family's resources have no relevance in the determination of a child's eligibility. The sole use of this information is to determine which Medi-Cal costs are matchable at the enhanced rate due to expanded Medicaid coverage for federally targeted children who, heretofore, were not eligible for Medi-Cal. As the government agencies administering the Medicaid program, we need to be sensitive to and minimize the amount of information we require from the public. Without this sensitivity, we will continue to place unneeded barriers to families enrolling their children into Medicaid.

As we indicated in our original state plan submission and in our February 6, 1998, response to HCFA's questions, California is attempting to cover the estimated 400,000 children who meet Medi-Cal eligibility criteria but who are not enrolled. A key part of this effort to cover these children includes an aggressive effort to remove unnecessary questions from the current Medi-Cal application form, simplify the form, and allow it to be a mailed in. We believe this approach is consistent with the approach HCFA has taken in its model joint application for CHIP/Medicaid. This model application does not include any resource questions. This is validated by the examples of applications from other states that HCFA has provided, none of which include any resource questions. Further, HCFA in its "Discussion of Promising Outreach Strategies" advises states to "Streamline the eligibility process, have simplified application forms in appropriate languages, and allow application by mail. Ask only for necessary information."

It takes 35 questions on the Medi-Cal application to capture sufficient information on family resources. In the Healthy Families Program, California is implementing the resource disregard for certain Medi-Cal children. We did not want to ask any of these 35 questions for the sole purpose of claiming the enhanced federal match for these newly covered children. Instead, in our State Plan we proposed that we claim the enhanced match using a sampling approach. In the response to our State Plan, HCFA expressed concern over the legality of such a sampling approach and to date we have not heard resolution to this issue.

Given California's need to finalize our application to meet our July 1, 1998, implementation date, senior HCFA staff advised California to add two questions to our application to identify families who have resources that would have, heretofore, failed the resource test. Based upon HCFA's advice, California added these two questions to its form. One question asked if a family had more than one car and the other asked if the family had more than

$3,150 cash in a bank account (the asset limit). We agreed with HCFA staff that it was a reasonable way to document the number of children who would previously have been denied Medi-Cal because of family resource albeit, and one that would probably result in under claiming of the enhanced match. This is because the two questions will not detect all conditions where the State is entitled to enhanced match such as when a family would have failed the resource test due to excess stocks and bonds.

As you are aware, California's new application form has come under public and media criticism for its complexity. Beneficiary and children's advocacy groups have asked the State to justify each element of data on the form. When we have not had a valid reason, we have removed the data element. These groups expressed concern about the addition of the two resource questions worrying that families may (incorrectly) think that a positive answer would mean that they did not qualify for Medi-Cal. We are very concerned that now HCFA is proposing that California include detailed resource questions on our application. At the extreme, HCFA's position would require the addition of up to 33 more questions to the application. To get additional detail on the single car question we would have to add 10 more questions, including information on the make, model and registration of the car, and whether it is used for work transportation or self support.

In the request for information, HCFA indicates that we are adding two questions on resources to "...assess whether children are eligible for the program..." Further, HCFA suggests that we establish "...a threshold amount above the Title XIX income eligibility, in which families within the threshold amount would then be asked qualifying questions beyond the two that were proposed, so as to further detail their resources." This approach is illogical given California's approach to eligibility. In adopting a resource disregard, a family's income becomes the criterion for eligibility determination. If a family's income, less income deductions, meets the Medi-Cal income criteria (133% FPL for children one to six and 100% for children six to nineteen), these children would be eligible for Medi-Cal. All children in the proposed "threshold amount above the Title XIX income standard" would not be Medi-Cal eligible, but rather would enroll in Healthy Families. As Healthy Families has no resource test, it would be of no value to ask these families for their resources nor would this information make the family Medi-Cal eligible.

California has adopted HCFA's recommendation to add two questions to the application. As discussed with HCFA, these questions should capture the vast majority of cases in which disregard of resources has allowed children to become Medi-Cal eligible. Adding questions would detract from our mutual goal of reducing barriers to providing Medicaid coverage to currently eligible children with little overall value added. We request that HCFA remove its

request that California add more questions to its simplified application form. Alternatively, we again propose the use of a sampling methodology if that approach is deemed preferable to HCFA.

Resource Disregard. California will follow federal law that precludes certain income from being counted in determining eligibility for federally means tested programs and will not count this income. In determining Healthy Families eligibility, California will not count income from the following sources:

- Disaster Relief Payments (federal disaster and emergency assistance and comparable assistance provided by State and local governments and disaster assistance organizations;
- Per capita payments to Native Americans from proceeds held in trust and/or arising from use of restricted lands;
- Agent Orange Payments;
- Title IV Student Assistance;
- Energy Assistance Payments to Low Income Families;
- Relocation Assistance Payments;
- Victims of Crime Assistance Payments;
- Spina Bifida Payments; and
- Any other federal income deduction required for a federal means tested program.

Some federal income deductions, such as Earned Income Tax Credit and Japanese Reparation Payments, apply only to certain federal programs and not all federally means tested programs, including Title XXI. In cases where the income deduction does not apply to Title XXI, this income will be counted.

Further, the Healthy Families program will share eligibility files with Medi-Cal on an ongoing basis to check for children enrolled in both programs. Additionally, a random sample of applications will be audited using the Income Eligibility Verification System (IEVS) on an on-going basis to verify that the incomes being reported were the incomes earned.

Private Coverage. The application will ask parents about their access to employer sponsored coverage. Children who have been covered under such

coverage in the prior 3 months will be determined ineligible.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM

All county expansion programs included in this state plan amendment proposes to follow the same screening procedures at the initial and annual eligibility review as those followed in the Healthy Families Program. Rules on income disregards, resource disregards and the three month separation period from private coverage all apply to C-CHIP enrollees. Initial applications and annual review applications that include a child who is applying for C-CHIP coverage but who may be eligible for no cost Medi-Cal or the Healthy Families Program will be forwarded to the State's Single Point of Entry for processing.

AIM

The program serves women whose family income is too high for Medi-Cal and who do not have employer sponsored coverage. The AIM administrative vendor verifies the income eligibility of families by reviewing income information submitted by families, either the previous year's federal income tax forms or current year wage stubs. Families eligible for no-cost Medi-Cal are denied AIM enrollment. If a family indicates on the AIM application that it has coverage through an employer, that application is not approved.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. (Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))

California is currently assessing whether it is possible to develop an application form which can be used both for Healthy Families and Medi-Cal for pregnant women and children. Until that form is developed (and its development determined to be feasible), such families will be notified of their potential eligibility for Medi-Cal and how to apply when their Healthy Families application is returned to them.

The state's outreach and community based organization activities will be coordinated between Medi-Cal and the insurance program. These efforts will aim to assist families in applying for the program under which they qualify, with a goal of directing families to the correct program at the point of first contact, in recognition that CBOs are often the health system's first contact with uninsured families with income under 200% FPL.

The state also intends to rely heavily on the state's CHDP program as an access point into coverage. CHDP providers will screen the children for eligibility into Medi-Cal or Healthy Families and assist families in filing applications for the appropriate program.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM

Even though each of the C-CHIP's has created their own application, they were all modeled after the joint Medi-Cal/Healthy Families application, hence the C-CHIP applications contain the same questions and have the same look and feel. As a result, the State's Single Point of Entry processing center will have the necessary information to make an eligibility determination. Once a child is determined Healthy Families eligible, the applicant will be contacted for a health plan selection and first month's premium payment.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. **(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))**

Establishment of California's Single Point of Entry (SPE)

The SPE, run by the Healthy Families administrative vendor, was established to 1) create a centralized location for the joint mail-in Healthy Families/Medi-Cal for Children applications to be received; and, 2) screen eligible children to Healthy Families or Medi-Cal as appropriate. The benefits that have resulted from the State's SPE are assuring compliance with the federal screen and enroll requirement, applying consistent eligibility criteria when conducting the Medi-Cal eligibility screen; streamlined application and enrollment process for families, and a central point of contact for county eligibility workers.

Application Process:

Applicants mail the joint mail-in application directly to the SPE. The SPE first screens all applications for no-cost Medi-Cal eligibility, and then routes the applications to either the County Welfare Department (CWD) or HFP as appropriate.

When applications are sent to Medi-Cal from the SPE and the children are determined to be ineligible for no-cost Medi-Cal due to income considerations or updated information, the CWD returns the application to the SPE with a transmittal form to indicate why the person is ineligible for no-cost Medi-Cal. The SPE has on-site liaison staff that is proficient in Medi-Cal eligibility criteria and can evaluate whether the information received or forwarded from

the county is sufficient to forward directly to HFP. The SPE liaison staff work directly with county staff on those applications in which the information forwarded to the SPE is not sufficient to support a definitive eligibility determination. This quality improvement effort has increased the standardization of eligibility determinations and reduced the unnecessary flow of applications between programs.

The State has further streamlined the enrollment process by providing alternatives to the standard joint mail-in application. A Medi-Cal application (MC 210) or the Medi-Cal Annual Redetermination form with a Notice of Action (NOA) and supporting documentation, is acceptable for use as an application for the HFP. Consistent with this policy, DHS has issued a letter, which instructs counties to forward the applications of no-cost Medi-Cal ineligible persons to the HFP. Applications that are initiated at or mailed to the county directly and determined to have children ineligible for no-cost Medi-Cal because income exceeding the Medi-Cal limits are forwarded to the SPE for a HF determination. These applications are forwarded with a transmittal form, NOA, and supporting documentation as available.

Medi-Cal Redetermination Process:

At the time of a Medi-Cal redetermination, if a child is determined to no longer be eligible for no-cost Medi-Cal because of income, the CWD forwards a transmittal, notice of action, and the supporting documentation to the HFP for a determination. Moreover, the SPE, MEDS, and the HFP administrative vendor's internal data systems interface. If a Medi-Cal or HFP enrollee has an income change before his/her redetermination and requests a redetermination to establish eligibility for the other program, each program has the ability to forward (or receive) information and supporting documentation. This information and process can be used to establish eligibility and maintain seamless health coverage.

Since the HFP's inception, the State has provided a "one-month bridge" which is a transition period for those children living in families with incomes that no longer qualify them for no-cost Medi-Cal. The one-month bridge continues the child's coverage for an additional month while the HPF makes an eligibility determination and the child is enrolled. Each person enrolled in a Medi-Cal health plan will continue his or her enrollment in the same health plan during the one-month bridge.

4.4.4. The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. (Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))

California will include provisions to minimize the potential for employers or individual employees do not drop their current dependent coverage to take advantage of subsidized coverage. Such "crowd out" seems to be a potential consequence of making available subsidized coverage for children. However, given that several researchers have found that crowd out is not a serious concern when subsidized programs are limited to children, the state is not sure how big a danger crowd out might actually be.[4]

Nonetheless, we believe that the measures we have adopted in our authorizing statute are among the best approaches to prevent crowd out. Features to avoid crowd out include:

- Establishes a coverage "firewall" -- a prohibition against covering children who have had employer sponsored coverage within 3 months prior to applying for Healthy Families. MRMIB is authorized to increase the length of the period to 6 months if it finds that Healthy Families is covering substantial numbers of children who were previously covered under employer-sponsored plans.

- The state has established exceptions to this limitation in cases where prior coverage ended due to reasons unrelated to the availability of the Program. These include, but are not limited to:

  - Loss of employment due to factors other than voluntary termination.
  - Change to a new employer that does not provide an option for dependent coverage.
  - Change of address so that no employer sponsored coverage is available.
  - Discontinuation of health benefits to all employees of the applicant's employer.
  - Expiration of COBRA coverage period.
  - Coverage provided pursuant to an exemption authorized under subdivision (I) of Section 1367 of the Health and Safety Code.

- Establishes copayments for non-preventive services.

- Prohibits insurance agents and insurers from referring dependents to

4 See Chollet, Deborah J., Birnbaum, Michael and Sherman, Michael J. of the Alpha Center, "Deterring Crowd-Out in Public Insurance Programs: State Policies and Experience" (October 1997); Children's Defense Fund, "Fears That Employers Coverage Will Fall If Uninsured Children Are Helped Are Exaggerated" (November 1997); and Center for Health System Change *Issue Brief No. 3*, "Medicaid Eligibility Policy and the Crowding-Out Effect" (October 1996).

the program where dependents are already covered through employer sponsored coverage. Violation of the provisions would constitute unfair competition under the Business and Professions Code.

- Makes it an unfair labor practice for an employer to refer employees to the program for dependent coverage where the employer provides for such coverage.

- Makes it an unfair labor practice for an employer to change coverage or change the employee share of cost for coverage to get employees to enroll in the Program.

- Directs MRMIB to develop participation standards that minimize "crowd out".

- Directs MRMIB to monitor applications to determine whether employers or employees dropped coverage to participate in the program.

MRMIB will monitor applications to determine whether employers or employees have dropped coverage to participate in the program. Specific monitoring strategies that the Board will consider include the use of a third party evaluator, and subscriber or employer surveys to measure the extent to which crowd-out has occurred.

The state is aware that HCFA is developing a crowd out policy and would be interested in commenting on that policy before it is adopted. HCFA should be aware that California, like many states, has adopted state legislation based upon the federal law giving states broad authority. We ask that HCFA keep in mind the impact of any such policy on state law and the state's commitment to make Healthy Families' coverage to uninsured children by July 1, 1998. Furthermore, California notes that the federal statute authorizing the "State Children's Health Insurance Program" does not provide the U.S. Department of Health and Human Services the authority to require states to meet national crowd out standards as a condition of eligibility for federal funds. While California is committed to remaining a leader in the development and use of strategies to avoid crowd out, each state should be allowed to set its own crowd out strategies without interference from Washington.

Exceptions. We would also like to raise with HCFA an issue that the State believes could exacerbate crowd out. The State believes that uninsured

children have a high, unmet need for dental services. For example, the most frequent medical need identified in health screens done in our Child Health and Disability Prevention Program (EPSDT for uninsured children with incomes above Medi-Cal levels) is dental services.

The State believes that an additional important crowd out mitigation measure would be to allow children with health coverage – but no dental or vision coverage – to buy dental and vision coverage through the program. We are aware that children with health coverage are ineligible for the Title XXI funded programs. However, permitting families to remain in their employer-based coverage while accessing the HFP dental and vision benefits could be an important mechanism for discouraging parents of children with little or no vision or dental coverage from dropping the employer-sponsored health care in order to access such benefits through the Healthy Families Program benefit package. We want to raise this issue to you as your consider any possible legislative changes to Title XXI or possible Title XXI waivers.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM

The C-CHIPs will adopt the same provisions as the Healthy Families Program to minimize the potential for employers or individual employees to drop their current dependent coverage to take advantage of subsidized coverage.

4.4.4.1. ☑ **Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.**

4.4.4.2. ☑ **Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.**

4.4.4.3. ☐ **Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.**

4.4.4.4. ☐ **If the state provides coverage under a premium assistance program, describe:**

The minimum period without coverage under a group health plan, including any allowable exceptions to the

waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

4.4.5. Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. **(Section 2102)(b)(3)(D)) (42 CFR 457.125(a))**

The provision of child health assistance to low income children who are American Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C.1603(c) (Section 2102)(b)(3)(D) or who are Alaska Natives (as defined in the Alaska Native Claims Settlement Act, 43 U.S.C. 1601), will be assured through the following procedures:

- Technical assistance by the state American Indian Health Program, Federal Indian Health Services, and tribes in tracking of services to American Indians.
- Inclusion of American Indian ethnicity using the federal definition on the application form for tracking purposes.
- Targeted statewide outreach media campaign and outreach activities through contracts with selected community based organizations providing services to American Indian children to assure that American Indian families are aware of the program throughout the state and to assist children in enrolling in the Healthy Families Program.
- Provision of training to local American Indian clinic staff for outreach and referral to the Healthy Families program.
- Use of the 30 American Indian primary care clinics (which are CHDP providers) to screen low income youth, provide initial treatment and referral either to Medi- Cal or Healthy Families.
- Provision to exempt American Indian and Alaska Native families, that meet the cost sharing waiver requirements, from monthly premiums and benefit copayments. This exemption will be made only when an AI/AN provides acceptable documentation showing proof of his/her AI/AN status. Acceptable documentation for the applicant or the child includes:

1. An American Indian or Alaska Native enrollment document from a federally recognized tribe; or
2. A Certificate Degree of Indian Blood (CDIB) from the Bureau of Indian Affairs; or
3. A Certificate of Indian Heritage from an Indian Health Service facility operating in the State of California.